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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

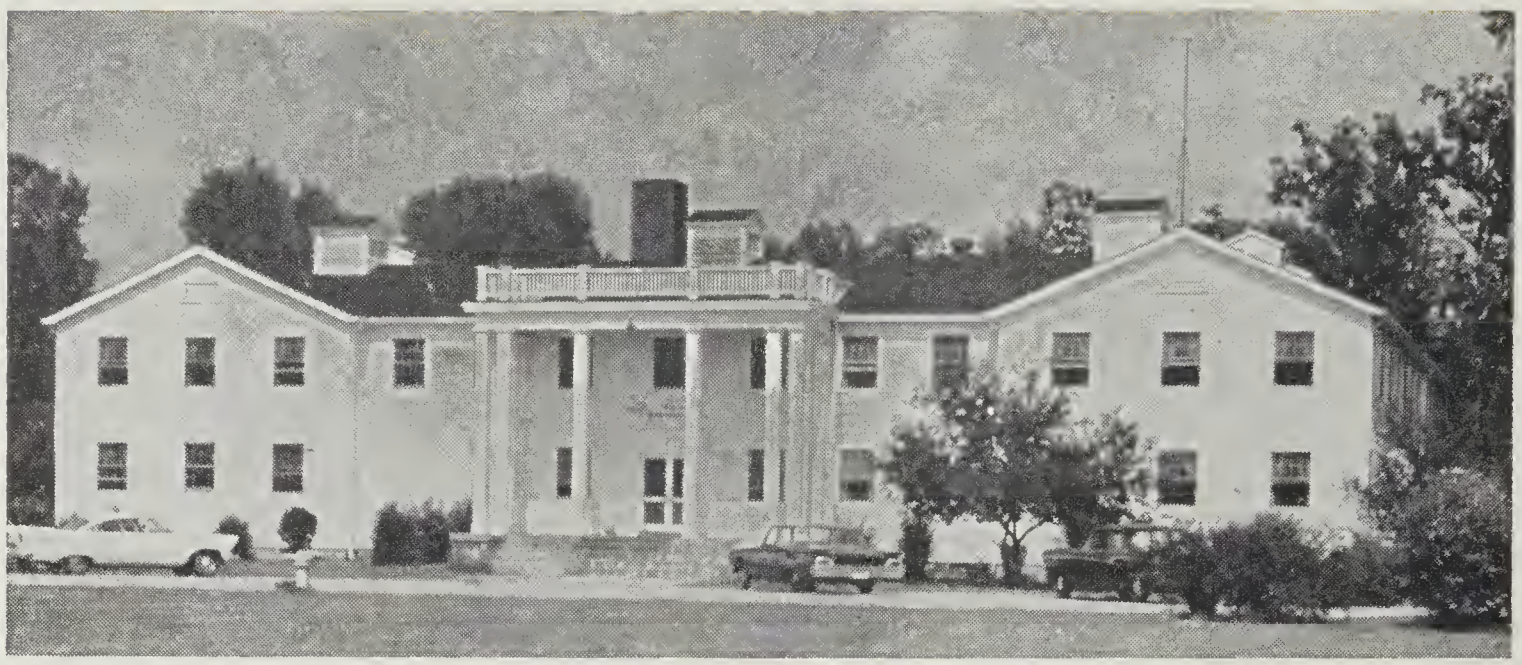
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, a psychiatric social worker, a chaplain and admitting officer, a vocational rehabilitation counselor, an activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Days

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P. M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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THE N. C. STATE MENTAL HOSPITALS MOVE CLOSER to the PEOPLE

BY NORMAN DESROSIERS, M.D.

Dr. Norman Desrosiers is presently acting director of the N. C. Alcoholic Rehabilitation Center at Butner. An ordained minister of the Methodist Church, he served as a chaplain at John Umstead Hospital for five years prior to entering the field of medicine.

FOR years, totalling centuries, an aura of mystery, suspicion, fear, myth and downright ignorance has, and to an observable degree still does, characterize the general public's concept of what a mental hospital is and what goes on inside.

Until recently the state mental hospital has been conceived of as an isolated, little known place where the peculiar person was sent to be kept—and that is all, to be kept—when he became either dangerous or such a nuisance that his presence was embarrassing. His return—more or less improved—to his home community aroused much speculation and prognostication, not always on the side of well-wishing or welcome. This public attitude, as we are so acutely aware of now, had a great deal to do with the individual patient's success in re-integrating into his family and community life. All too often family or community conditions were unfavorable for the continued improvement of the patient, and he had to be returned to the hospital.

Fortunately, however, as a result of the efforts of many people and organizations who have worked for better care of the mentally ill and education of the public concerning mental illness, some of the irrational ideas and feelings toward the mentally ill individual as well as the hospitals which treat him are slowly changing. The day of the isolation of the mental hospital is experiencing its sundown.

In the last ten to fifteen years a tremendous increase in funds has been appropriated for better housing and psychiatric care of the mentally ill in North Carolina. But, in spite of increased public interest and larger expenditures, the hospitals have remained semi-isolated from the local communities which they serve. Patients have been returned to the same conflictual environment from which they came—an environment of people and situations which have had some part in precipitating the patient's emotional disturbance. The inevitable result has been an ever increasing rate of re-admissions.

Treatment methods are better; tranquilizing drugs have been a great boon to facilitate psychotherapy; psychiatric staffing is better, though woefully too few in number; patients do respond to therapy more rapidly; yet, they come back to the hospital at an ever-increasing rate! Why?

Among a host of possible reasons for the re-admission problem, one stands out with considerable clarity —the almost total lack of follow-up care after release from the hospital. The unreasonable expectation of both family and community that the patient be able to step in and function in all his various roles has been indulged in and, too often, the stress of these demands, though assuredly

unwitting in many instances, is enough to overwhelm the patient, re-precipitating his illness. In such instances the patient may have needed support—and perhaps the family as much support and understanding as the patient—until strengths developed and demands decreased in proportion. In the absence of local professional services to provide support, the only recourse for the patient is return to the hospital.

Another contributory factor to patient relapse necessitating readmission in some instances is improper drug management. With the advent of the use of psycholeptic drugs many patients were sent home with the recommendation to continue on these drugs for varying lengths of time. Some patients without continued encouragement often discontinued the drug prematurely and promptly relapsed. Some general practitioners, who were not familiar with the drugs being used, became alarmed at the apparent magnitude of dosage and reduced dosages unwisely, initiating relapse or worsening of the emotional state of the individual. Over-medication or inadvisable prolonged use of drugs has been frequently observed and, in certain diagnostic categories, has definitely aggravated the emotional balance of the individual.

Isolation of the state mental hospital is experiencing its sundown through local aftercare clinics.

Norman Desrosiers, M.D.

It has been realized for a long time that the greatest loophole in the armementarium of treatment of the mentally ill is the lack of an adequate aftercare program. Every experienced mental health worker knows full well that the environment most conducive to mental health is an emotionally healthy community and family environment, *not* the *mental hospital* environment which often works against the patient rather than for him. It is important to the concept of aftercare to realize this fact: the mental hospital is only a place for the care and intensive therapy of acutely disturbed persons for brief periods of time from which they should be returned, as soon as it is deemed clinically wise to do so, to a favorable home environment where therapy should then be continued. It is this basic principle that lies behind the new aftercare program that is being developed by North Carolina's mental hospitals.

The initial location of aftercare or outpatient clinics was arrived at through statistical studies of re-admission rates by counties. At the present time there are ten clinics being conducted at Burlington, Charlotte, Durham, Greensboro, Raleigh and Wilson, and at each of the state's four mental hospitals located at Morganton, Goldsboro, Raleigh and Butner. The report that follows is based upon the first six month's experience in the initial development of one of the aftercare clinics.

This particular clinic was launch-

ed at a county hospital in September of 1961 after proper liaison with the county medical society, hospital staff and other community agencies was established. Staffing consists of one doctor and one psychiatric social worker who devote a full working day per week to the work. In six months demands for its services had grown to the point of requiring that more time be given to the project.

Priority of time was assigned to the primary function of the clinic—that of aftercare or seeing former patients who have recently been released from a state mental hospital, which was the reason for establishing the clinic in the first place.

One facet of aftercare has been the regulation of medication following discharge from the hospital. Many reactions, side-effects and inadequate or overdosages do occur under different interpersonal and social environmental conditions which can be adequately controlled on an outpatient basis.

An excellent illustration of this point is a patient who had been treated four months in the hospital for a moderately severe depressive reaction. She came to the clinic for one session after discharge in a definitely agitated state declaring that she had been restless for three days and sleepless for two nights. The other classical signs of depression, however, were not present. It was discovered that she had been taking a drug for dysmenorrhea which contained an amphetamine preparation to which she was quite sensitive. Discontinuance of the preparation was followed by prompt relief of both the restlessness and the concomitant anxiety over the possibility of the recurrence of the depression.

It should be remembered that the tranquilizing drugs are no cure for emotional illness, but rather function as adjuvants to the more definitive treatment of psychotherapy and practicable environmental therapy. They should not be analogized to the chronic use of such drugs as digitalis, thyroid hormone, or insulin, with the exception perhaps of the hospitalized severe chronic cases. It would be better to think of their use along the lines of antibiotic therapy —to be used in adequate doses for a long enough period of time to do the job, but not so long as to condition the super-infection of emotional over-dependency upon them. Where stress is encountered in the convalescent period, and a temporary increase in medication is indicated, then it is given at the aftercare clinic. As a general rule, however, the ultimate goal, where it is deemed clinically possible, is to gradually eliminate the use of these drugs.

Basic Purpose

Since any form of medication for mental illness is but adjuvant therapy to the more definitive attempts to resolve emotional disturbance by psychotherapeutic means, attention to drugs is not by any means the most important function of the aftercare clinic. Its basic purpose is to offer psychotherapy to those who seek its services. Two main types of psychotherapeutic intervention are offered in the aftercare clinic situation: individual psychotherapy and a more extensive group psychotherapeutic approach.

The fact that the aftercare clinic allows any given physician or psychiatric social worker a prolonged contact with the patient gives an advantage of long-term treatment that is not always available in the hospital setting. After hospitalization many patients are referred to the clinic for continued support for varying periods of time. It appears from the many such contacts made already that the patients feel a great

deal of security in knowing that there is someone who knows them to a degree and to whom they can go when things just do not "go right." Relatives of patients also have sought out this supportive relationship in order to come to understand for themselves what is going on with the patient.

The value of repeatedly applied encouragement and simple understanding should not be underestimated, for in the interpersonal environments of many of these people, such positive attitudes simply do not exist. The majority of aftercare contacts are of this nature and individual interviews usually do not run over thirty minutes each.

The greatest therapeutic challenge and opportunity lies in group psychotherapy for it is here that the more prolonged effort can be made. Group psychotherapy offers many advantages, particularly to the voluntary patient who can continue with the therapy uninterruptedly at the outpatient clinic after only one month's experience with it during hospitalization. With groups being quite workable up to ten in number, two groups a day can offer a considerable number of therapeutic hours. And besides being economical in terms of being able to see more patients in a limited period of time, some authorities feel that the group situation offers a greater range of therapeutic effectiveness than individual therapy. For instance, it has been repeatedly suggested, and some feel demonstrated, that the group process has been more effective in helping the alcoholic patient.

Because this particular aftercare clinic is located in an area where psychiatric services are not readily available, it was felt that limited consultative services should be offered to local physicians and agencies. Seldom does a Wednesday go by that there is not at least one request on an early-as-you-can basis. Some weeks it has been necessary to send the "over-load" to the nearest mental hospital outpatient clinic in order to get help for the patients earlier. This service has to some degree also been useful to physicians as a screening function in deciding whether or not to recommend hospitalization as well as indicating what medication or therapeutic approach to use with the patient. Other agencies, groups and professional persons also have requested consultation, including the local police, welfare, and health departments, ministers, and personnel managers of the larger industries.

What began as a limited service has, in reality, become one of the clinic's main functions—as time allows. In this function, however taxing, a real community service is being successfully carried out—more evidence of the fact that the mental hospital is reaching out in its service to the community where the problems are, getting closer to their source, and making an attempt to attack them perhaps earlier than they otherwise might come to notice and, consequently, being more successful in its therapeutic attempt.

The purposes of the aftercare clinic as they have evolved are primarily aftercare and secondarily, consultant and screening admission services. Therapeutics, however, should not be the only concern of the clinic for, in moving into the community and making itself a community resource, it inevitably becomes a bureau of information, advice, and direction with respect to the preventive aspects of psychiatry, mental hygiene. It was felt, therefore, that a greater and more effective service could be rendered to the community by establishing liaison with the local public service facilities. The primary purpose in these relationships was to de-

velop the local personnel to better meet the mental health needs of the community.

The functions of providing therapeutic services, developing the local personnel, as well as carrying on a number of mental hygiene activities, are felt to consist of the responsibilities of the aftercare clinic.

The mental hygiene emphasis of the program was started with the community and business leaders in the city, in this case, the local community council. Through the efforts of the local mental health association, an invitation to address this group concerning the operation of the clinic, its purpose and philosophy, was received in November. Emphasis was placed on the primary purpose of the clinic, but those present at the meeting, which was attended by a full representation of community leaders, were given to understand that as time, as well as personnel, became available, a gradually increasing service could be rendered to the community.

In dealing with problems of an emotional nature, there are all levels of difficulty of adjustment from the very mild disturbance to the profoundly disturbed psychotic. Just as there are these different degrees of emotional disorder, so, also, are there different levels of therapeutic requirement from the simple settling of an argument between two persons to the necessity for professional psychiatric service and hospitalization. The obvious corollary, of course, is that there are many professional workers in allied fields who are perfectly competent to handle many of the less difficult cases and, in some cases, more competent and in a better position to do environmental manipulation with local resources than is the professional psychiatrist.

With knowledge of this sort, the personnel of the aftercare clinic were aware of the great potential of professional groups already existing in the community who were quite willing and ready to assist not only in the tremendous job of educating a community to the facts of mental illness and the resources of treatment, but also to begin to get across some mental hygiene concepts as well. The first efforts toward the development of available personnel were made through the public welfare and health departments.

With the ready cooperation of the heads of these organizations, a permanent weekly meeting for one hour was scheduled. Subject matter selected for the first five months was basic aspects of psychiatric knowledge which would give some common working ground for later work with actual cases.

Continuing Relationship

The response of individual caseworkers and nurses was heartening, and soon a full complement of both groups was attending. Later, vocational guidance counselors from the local high schools began to appear on a regular basis and became participants in the course. A continuing relationship has now been established with these workers on a bi-weekly basis at an hourly meeting during which actual cases, presented by the workers themselves, serve as a basis of discussion and a further learning experience. With increased knowledge and experience in dealing with less severe emotional disorders, these workers render a valuable service by giving actual consultation within the existing structure of their agencies. More serious cases are referred directly from the agency workers through their supervisors to be seen in the aftercare clinic.

Another major community resource of importance in both the treatment and prevention aspects of

mental illness is the clergy. Many of the clergy in this day and time are very much interested in the problems of emotional disorder and are trained to an ever increasing degree in the practice of pastoral counseling. These clergymen, in their daily relationships with their parishioners, are in a very strategic front line position in the battle against mental illness and, probably, in an unequalled position to teach basic principles of mental, as well as spiritual, hygiene or health. There are, unfortunately, a few counselors of renown who have been popularized and who tend to overshadow the good day-to-day type of therapeutic relationships and teaching done by the well-trained and dedicated clergyman in his office, in the hospital, and, of considerable importance, in his people's homes. This statement is made in spite of notorious examples of poor showings by some minority groups and individual clergymen who have left such a bad impression on the medical profession. Good and helpful work is being done by the clergy who are seeking to know more and to be of greater service in this closely related field.

The clergy of the area soon became aware of the existence of the aftercare clinic. An offer to establish a seminar-type training course of eight hours was accepted by the local ministerial association and carried out in four Tuesday evening sessions. Again, attendance and participation were gratifying. A dozen or so from a group of thirty ministers evidenced a desire to witness a group psychotherapy session in operation at a hospital and participated in another hour of discussion after the session.

Another very important resource group of public servants who are in close day-to-day contact with people in trouble is the local police department. Are they not in constant contact with the very people who ostensibly need the most psychiatric help: the lawbreaker, the juvenile delinquent, the drug addict, the sex offender, the suicidal, the alcoholic, etc.?

Ground had already been broken with the local police force due to the interest of an informed and enlightened police chief who had sponsored a ten hour seminar the previous year. At his request, however, the course was repeated, this time with more emphasis on some of the medical aspects about which the force felt it needed more information. Attendance, which was voluntary, was almost 100 per cent, with a considerable number of a neighboring town's detective squad attending as well.

The four two-hour seminars held were profitable for both the instructor and the police officers. The former heard first hand the problems, fears, and superstitions held about mental illness; and the latter gleaned new insights into motivations of behaivor, learned to recognize emotional disturbances, and gained some knowledge of treatment resources and what to do in certain situations.

The desire on the part of the police officers to know how to handle violent persons, for instance, prompted the use of an attendant from a mental hospital who had long years of experience in this area. He spoke to the group illustrating some of the techniques as well.

The role of the police officer in the initial and proper handling of many types of cases is tremendously important, though often overlooked. To illustrate how seminars can help in this area, we cite a case which was well handled by a police sergeant after some exposure to a training seminar.

The case involved a previously quite successful young male who for

two years had been deteriorating more and more through the use of alcohol. He finally came to the attention of the police department for making lewd telephone calls to young women. With considerable native insight and some recently acquired understanding of human behavior, the officer was able to discern an emotional illness in the offender, correctly perceived that a facial disfigurement was a contributory factor, wisely sought psychiatric counsel and hospitalization, and was able to avoid the damaging effects of imprisonment upon an already shaky ego structure.

The outpatient clinic's mental hygiene concern has not neglected one of the most important areas—the school. As has been indicated, vocational guidance counselors in the high schools joined the weekly sessions with health and welfare workers, evidencing their interest in psychiatric concepts and applications. One can safely speculate that they are confronted daily with many examples of erratic adolescent behavior, and that they came seeking some understanding of behavioral motivation.

Educative efforts with schools were not confined to high schools. Through the P.T.A. a large rural grade school was approached, it must be confessed, with considerable temerity—first, because it was feared that the attendance would be its usual small group and secondly, because of the possible threatening nature of the subject. But the apprehensions were in error, for the auditorium with a seating capacity of 500 was practically full of parents, teachers, clergymen and visitors from neighboring schools. It soon became apparent that this was a group of parents who were intensely interested in what their children needed emotionally as well as intellectually and physically.

The grade school, because of its tremendous influence on the child in his later formative years, is perhaps one of the most vital areas of concern in the mental hygiene efforts of clinic personnel. So much of living and the establishment of patterns of interpersonal relationships occur here that mental hygiene-minded personnel should expend a considerable portion of their energies in this area.

The two largest high schools, in another effort, were approached in a different way. Sessions were held with the students. In each instance, an outside person was obtained to speak on the subject of the adolescent and his strivings, goals, needs, etc. Following the talk, the student group, approximately 200 at both schools, broke up into smaller groups of 25 to 30 for discussions, each led by a professional counselor (educator, psychologist, social worker, psychiatrist, physician). After 75 to 90 minutes of discussing anything that came up in a relatively non-directive fashion, the groups re-assembled for a round-up summary session.

The personnel involved in the above evening sessions realized full well that they were on new ground as well as the students. Nevertheless, a beginning was made and, at last report, the students were clamoring for more. In essence, these efforts were social psychiatry in action and, though experimental, extremely interesting to experience and possibly a highly meaningful approach to mental hygiene practices.

So far in this discussion of mental hygiene, that is, about getting mental health ideas and information across, we are still removed by an intermediate (school, public service organization, professional group) from the layman to whom the infor-

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Organization and Development of an Inpatient Program for Alcoholics within the GENERAL HOSPITAL

BY JACK D. GORDON, M.D.

The acutely ill alcoholic often desperately needs inpatient care.

IN recent years we have witnessed growing recognition and acceptance of the concept that alcoholism is a disease process. Alcoholism has an etiology, pathology, and treatment like any other disease. In order to explore all its facets we should engage the disciplines of sociology, psychiatry, biochemistry, pathology and the public health sciences. Alcoholism is more complex than some diseases, less complex than others, but it is a disease process.

If we accept this premise, then, as conscientious practitioners in the health sciences, we must accept the responsibility for treating these patients, just as we treat all others.

The treatment of alcoholism is primarily an outpatient activity. The acutely ill alcoholic, however, often needs inpatient care. This responsibility is being assumed by the general hospital, which has available the technical facilities necessary to handle some of the more severe complications of prolonged drinking. Admission and treatment may be a life-saving endeavor.

The prospect of admitting alcoholic patients for treatment in a general hospital is certain to provoke a variety of strong reactions. The board of directors will be fearful for the good name of the hospital. Often a prohibition against the admission of alcoholic patients is written into the hospital constitution. The nursing staff is apt to be anxious and alarmed in anticipation of added work, and from the possibility of coping with a difficult, if not entire-

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ly unmanageable, patient. The staff physicians are going to wonder what the effect of an uncontrollable, noisy patient will be on the well being of a coronary patient in the same room. Yet, alcoholic patients have always been admitted to general hospitals, some few cases openly and in other cases under one disguise or another. Mount Zion Hospital in San Francisco has been routinely admitting alcoholic patients without segregation, private rooms, or special nurses, and on first come, first served basis, since 1957. It is my purpose today to recount briefly some of the experiences we had in organizing and developing this program, then to propose a method, based on our accumulated experience, of organizing a similar program applicable to a wide variety of hospital situations.

The alcoholism program at Mount Zion Hospital in 1957 was primarily a demonstration study program to determine if it were feasible to admit acutely ill alcoholics in an unsegregated hospital setting. It was underwritten by an agency within the State Department of Public Health. The study team consisted of a medical director, a psychiatrist and the hospital administrator. Two social workers, the chief nurse or her representative, and a sociologist also took part in the planning and development. In addition, a psychiatry resident was assigned to the program. The patients came from two sources: the Adult Guidance Center, a San Francisco outpatient facility, and those referred by staff members of the hospital.

Sixty-two patients were admitted and closely studied in this phase of the program. A detailed account is available in the Hospital Monograph Series No. 7, published by the American Hospital Association. The initial program was primarily a study effort and is not intended necessarily as a model for other hospitals. When this demonstration program was concluded the ongoing program was supervised only by the medical director. About 200 patients per year have been handled in this manner, with only minor modifications in the basic routine. Based on the conclusions of the original study and our subsequent experience, we feel that the following plan is applicable for use in any general hospital contemplating the admission and care of acutely ill alcoholic patients:

Administrative Team

First, an administrative team is set up. This should consist of the medical director, a psychiatric consultant, the chief nurse and a representative of the hospital administrator. If social workers are available, they can enhance the program in many ways, particularly in arrangements for follow-up treatment. The medical director might be any interested physician with some experience in handling alcoholic patients. He should be available for consultation and advice at all times. The psychiatrist should have a special interest in the psychodynamics of alcoholism. His advice and counseling on the psychological aspects of handling these patients will prove invaluable. This basic group should meet regularly.

The second step consists of the training program of hospital personnel. Two one-hour sessions, with required attendance by all nurses, aides, orderlies and emergency room personnel, together with representatives of the administrator and the admitting office, constitute a minimum effort. The first lecture should consist of a basic description of the physiology of alcohol and the disease processes produced by it. A surprising interest in the rudimentary aspects of alcohol metabolism and

the significance of blood levels will ordinarily be shown. The complications of alcoholism, such as cirrhosis and neuritis, are then outlined. A description of the acute alcoholic states, such as basic withdrawal symptoms, alcoholic hallucinosis, and delirium tremens, are described with great care, because these are the complications which generate the most anxiety in those caring for the alcoholic patient. Finally, a careful and thorough description of treatment methods is outlined. This is perhaps the most important portion of the initial lecture. The use of newer tranquilizing drugs, such as promazine and meprobamate, is described in detail. If one remembers that the listening audience of nurses is basically afraid of the alcoholic patient, the reassurance which is given by thoughtful description of treatment procedures, designed for the successful management of these patients, can hardly be overestimated. At all times alcoholism is treated as a disease process and the alcoholic patient as a sick person. The comparison of this chronic disease to diabetes mellitus, which is also characterized by recurring episodes such as acidosis and coma and with certain peripheral complications such as neuritis, provides an understandable analogy.

The second lecture should be given by the psychiatrist. This session fulfills many important functions. It brings into focus some of the psychological motivations of drinking, such as the attempt to relieve severe anxiety and depression. It may be shown that the common stereotype of the Skid Row, degenerated personality constitutes a small proportion of alcoholic patients. An attempt is made to portray the reasons for much of the resentment toward treating alcoholic patients. The moralistic conception of alcoholism is opened to question. The question and answer portion of this lecture is apt to bring forth these questions:

How does one speak to a patient who is describing hallucinations? What does one answer to the patient in the next bed if he inquires if his roommate is an alcoholic? Will this program cure the alcoholic?

The answers to these questions should always carry the connotation that these patients are treated quite like all other patients. It is necessary to point out that overprotective or patronizing attitudes might produce counterhostility and anxiety in this group of patients, just as hostility and a punitive attitude is certain to do. It therefore cannot be overemphasized that the proper therapeutic attitude is to treat alcoholic patients *exactly* as all other patients.

Next, a basic medical treatment protocol should be drawn up, and adherence to it should be a condition of the staff privilege to admit and treat alcoholic patients. It should consist of the initial use of promazine or chlorpromazine by intravenous or intramuscular injection. Meprobamate or a similar tranquilizing agent is given orally when possible. Chlorohydrate is given in capsule form for sleep. The use of adrenal steroids and ACTH is limited to exceptional cases. Certainly, many variations from this routine may be anticipated. The use of anticonvulsants in the patients with a history of "rum fits" should be explained. Alcohol, barbiturates or narcotics are avoided. The basic combination of promazine and meprobamate have been the mainstay of the Mount Zion treatment routine. Most staff physicians did not resent the idea of treatment protocol in this particular disease because they were anxious to find out what the later and most effective remedies were.

Next, a specialized admission pro-

cedure should be employed for alcoholic patients. They should be admitted to the emergency room in the company of a relative or a responsible friend. There they should be examined to assess their general condition and to see if any contraindications to strong tranquilizing drugs might be present. Here the initial sedation is given. It should consist of the equivalent of 50 to 100 mg. of promazine intramuscularly or intravenously, depending on the state of agitation. When the initial sedation has definitely taken effect, then, and only then, is the patient transferred to his assigned room. This is a most important step in the admission procedure. It is in this setting that the alcoholic patient first recognizes a true treatment facility, interested professional personnel, the prompt effect of the drugs, and the subsequent relief of his symptoms. The activities in this area may well color the entire admission. When the patient is transferred to his room he must be accompanied by adequate sedative orders consisting of no less than 50 to 100 mg. of promazine intramuscularly plus all orders for tranquilizing drugs. In all cases the floor nurses must be told the exact diagnosis. Whatever the concomitant diagnosis, such as gastritis, etc., the nurses must be made aware of the basic alcoholic nature of the problem.

At the beginning of the program, a screening procedure should be agreed upon and supervised by the medical director. Violent, combative patients, or those with known psychotic behavior, should be excluded. It would be wise to see that the first patients should be relatively "easy" patients and drawn from the ranks of "respectable" people from a variety of professions and skills. The completely unknown or badly deteriorated patient should only be admitted at a later time when all personnel have had increased experience in the management of alcoholic patients. The usual alcoholic states leading to admission and susceptible to management in a general hospital are: simple withdrawal "shakes", alcoholic hallucinosis, mild delirium tremens, and gastritis with vomiting. This group of patients presents very few management difficulties when handled in the above manner. Very close supervision by the medical director is advisable, particularly at the beginning of the program. The Mount Zion studies have brought out many useful findings. Especially noteworthy was a marked change in the attitude of nursing personnel toward alcoholics. Prior to the training program, 55 percent of nurses responded with negative attitudes on questions pertaining to the admission and care of these patients. At the conclusion of the program, 80 percent showed positive attitudes. The program is now regarded in a matter-of-fact way by both staff and nursing personnel.

Alcoholic patients have always been susceptible to management problems. We believe that with observance of the outlined methods, these problems may be minimized. A review of records of patients admitted under the diagnosis of "gastritis" and "cirrhosis" showed 25 percent to be acutely intoxicated. Of these patients, 42 percent presented significant management problems as extrapolated from nurses' notes. Among the first 62 patients in the study program, only 11 presented any unusual problems, (18 percent). When the unrestricted admission of alcoholic patients began there was a notable rise in management problems leading to unusual incident reports. This was not unexpected, and was ascribed to the decrease in sup-

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THE ALCOHOLIC PATIENT

BY THERESE M. LaLANCETTE

MENTAL HEALTH NURSE CONSULTANT
U. S. PUBLIC HEALTH SERVICE

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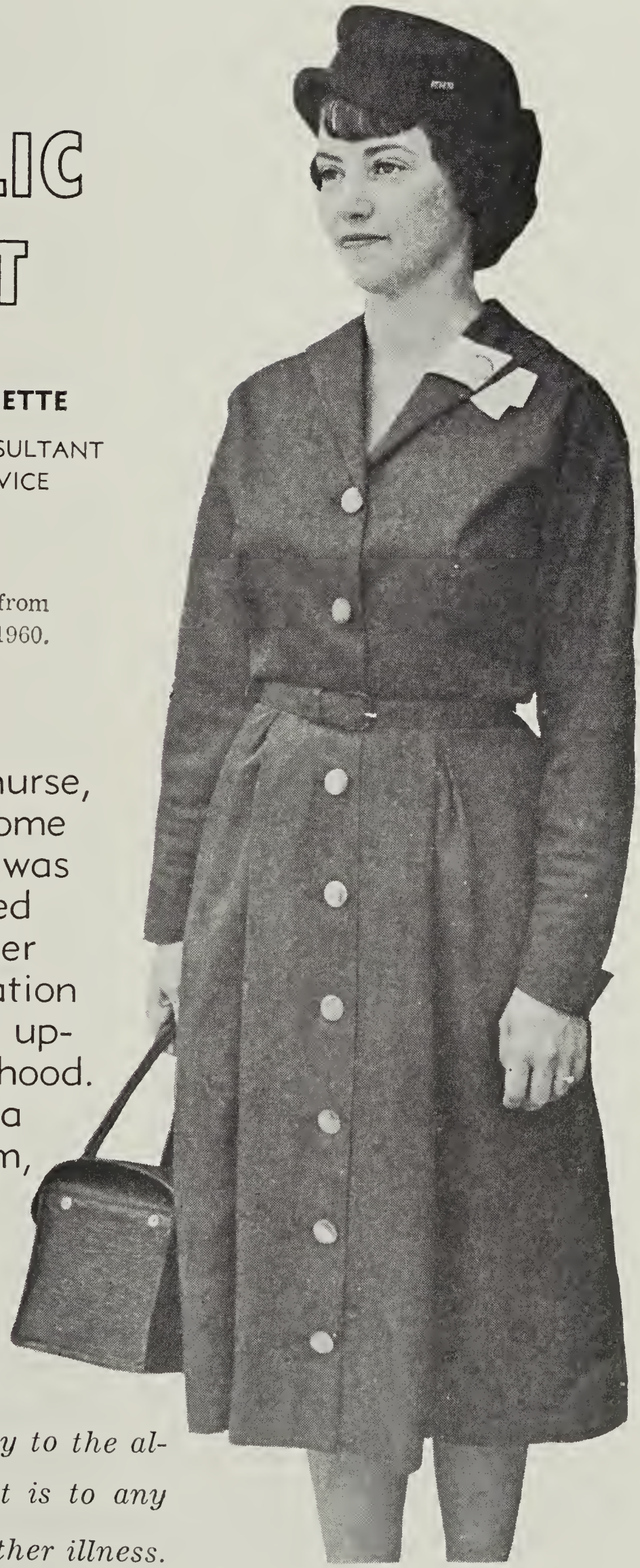
Nursing Outlook, November, 1960.



A public health nurse, on her way to the home of her next patient, was stopped by an excited woman who asked her to look in on a situation which was obviously upsetting the neighborhood. She followed her to a dingy, cluttered room, and there found a middle-aged woman in an alcoholic coma.

The nurse's responsibility to the alcoholic is the same as it is to any other patient with any other illness.

She called the emergency unit in the district to send an ambulance, and, while waiting for it, attended the patient, who had been incontinent, was filthy, pathetically undernourished, and surrounded by empty bottles of alcohol.

The police arrived, bundled the patient into the ambulance, and rushed her to the hospital, where she was given the necessary medical and nursing attention. This is a familiar story.

Nurses in public health and in the hospital have always had to cope with the problem of alcoholism. But since it has become one of the leading medical problems in the country, they have sought a more specific definition of their functions in relation to its treatment.

What is our responsibility as nurses to the alcoholic patient? It is simply to do the best we can to meet his needs—physical and emotional. We have the same responsibility to him as to any other patient with any other illness. Yet, as is often the case, this patient is unattractive to us. He is different from the usual patient we attend without hesitation. One of the reasons for this is that our society does not regard the alcoholic as a responsible citizen.

The alcoholic does not hold up under the usual stresses of life; his behavior reflects loss of self-control. He is often belligerent, argumentative, uncooperative. He promises to stop drinking and doesn't. He bears the marks of a man who is destroying himself. Indeed, he *is* socially unattractive.

The surgical patient neatly recovers and returns to society as a useful citizen. The handicapped patient struggles to compensate for his disability. Our diligence in the care we give these patients is rewarded.

To see a young mother become adept in the care of her baby as a result of our efforts is refreshing. When the patient with a terminal illness dies, we experience the satisfaction of having given him and his family care and comfort before his death. These patients want our help and are benefited by our efforts. These are the rewards we recognize as coming with our profession.

Rejects Help

But what about the alcoholic? Often he will not let us help; he rejects or demands; he disappoints us. He is visibly destroying himself, and may want to do just that. We know that the malignancy of self-destruction is as damaging to the psyche as cancer is to the tissue. But the cancer patient is respectable, the alcoholic patient is not.

We must remember, however, that it has been only within the last ten years that cancer patients have made public their diagnosis. Such famous persons as John Foster Dulles, Oscar Hammerstein, and Humphrey Bogart have helped to remove the stigma.

Only within the last few years has the alcoholic been considered a medical responsibility; he is still on the threshold of being accepted as a medical patient.

Until recently members of the medical profession, with justifiable reason, have seemed insensitive to the alcoholic's problems, perhaps because they have felt so helpless in the face of the hopelessness portrayed by the alcoholic. Some physicians, including psychiatrists, have wanted nothing to do with the treatment of the alcoholic because he is so very difficult at times. One psychiatrist who for twenty years worked exclusively with alcoholics said of his experience that in all that time he had had "some success."

Various theories have been advanced regarding his sociologic and

biologic make-up, but none has been proved. As an entity, he is a unique composite of symptoms and dynamisms. There is general agreement, however, on his basic personality structure.

The alcoholic, particularly if he has suffered from extreme emotional deprivation since infancy, trusts no one enough to establish a lasting relationship. And when he does relate, he does so on a child's level—demanding of adults what a child demands of his parents; namely, love, protection, and security.

It is not easy to understand that his belligerent, braggart, fighting exterior is a defense against exposure of his excessively dependent interior. The loneliness of an alcoholic is an emotion that is fathomless to comprehend.

On the more encouraging side of the picture are the great strides that have been made during the past few years in the medical and mental health fields. Alcoholism clinics, special wards in the general hospitals, alcoholic farms, half-way houses and aftercare clinics have been established.

The rehabilitation programs developed by industry have reached the point of success at which alcoholism is no longer considered a "top secret" disease in that setting.

The medical profession now insists on humane treatment for alcoholics. Progressive hospitals no longer allow them to reach the stage of delirium tremens. Compare this with the era when the terror-stricken patient was strapped to a bed and left screaming while his delusions loomed before him. Today we know that a person already frightened becomes unbearably so when restrained, and especially when this is done by unsympathetic hands.

Medical and nursing schools in various parts of the country are considering including the study of alcoholism in their curricula. Two nurses, to my knowledge, have written their masters' theses on this subject.

I think we would all agree that the best time for the nurse to learn the symptomatology of the disease and how to deal with the afflicted person is while she is still a student. Accepting an alcoholic is not easy for the young nursing student, however. One student refused to do a case study on a patient because "he is just an alcoholic," and another was extremely angry when she learned that a dear little woman was diagnosed an alcoholic. These reactions are typical of those with which nursing instructors must deal. An alcoholic does not fit into a student's stereotype of the patients she wants to care for.

Most of us have lived in an environment that has bred and supported moralistic and judgmental attitudes toward the alcoholic. Some of us harbor antagonism derived from experience with a family member or a friend, and resultant feelings toward alcoholics are those of shame, hurt, resentment, and prejudice.

For this reason it is important that all nurses, including students, acquire thorough knowledge of the medical and psychological aspects of this disease. Much progress has been made in recent years, but this is only a beginning; for most alcoholics the outlook is still grim. Those who do not die in an alcoholic coma may land in jail, an emergency ward, a psychiatric hospital, a mission shelter, or on some doorway. The alcoholic who has a home is seldom welcome in it. Here he is a target for the anger, cruelty, and pompous righteousness resulting from the resentment of those he has deserted. If he is sent to jail, he is locked up

(Continued on page 18)

WILLINGNES

BY VERNE

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from the
issue of 7

The alcoholic and those wanting t

a great deal of themselves if th

HOW much are you prepared to invest? This sounds like a question posed by a broker, not a physician. But as a physician, I would like to pose this question to two groups of people—alcoholics and those interested in "doing something about" the alcoholic.

Patients constantly state that they want to stop drinking; that they want more out of life than they now get; that they want the people to understand and help them. Most of us who are involved with alcoholics, either personally or in business, or as just civic minded citizens, talk and write a lot about the seriousness of the problem and how much should be done to help these patients, etc.

There comes a time when just talking about it isn't sufficient. We must all, patients and interested outsiders, do something about it. It is at this point that we must each ask ourselves the important question—"How much are we willing to invest?" It's not easy to answer. Wanting things to be different is one thing; being willing to put out enough of our own sustained personal efforts to accomplish it is another.

For the patient, wanting a new way of life means a great deal more than to merely stop drinking. Although this is an essential first step, it is only a first step. Frequently the steps that follow are even more difficult and frightening. When the drinking stops, the process of building a new way of life starts. This can be tremendously difficult and requires years of constant effort. He must be willing to stand all the pain and discomfort for which he previously found relief in alcohol. He must get close to people—get to know them and really let them know him. This can be terribly frightening—they may not like him—they may reject him—they may even try to harm him. All this he must risk.

He must also be willing to assume the responsibility for all his actions. He can no longer blame alcohol for his hostile or antisocial feelings and actions. It may also mean that some people don't like him as well when he's honestly sober as they did when he was

TO INVEST

E FOX, M.D.

permission
uary, 1962
New Life.

elp him must be willing to invest

objective is to be accomplished.

drinking. And what about the rest of us who say that we want to help the alcoholic get well? Do we mean that we *want* to help *him* or do we really mean that we *want him* to stop drinking?

We expect him to give up alcohol and to be willing to do all these things in order not to fall back on it, but what are we willing to give in return? Are we willing to stand by him while he undergoes the temporarily crippling process of changing? Will we still accept him when he allows us to really see the resentment and hostility he feels toward us—without our being able to pretend it's not there because he was drinking when he said it? Are we willing, in turn, to let him get close to us and to really know us? Are we ready to stop blaming everything that goes wrong between us on the fact that he drinks?

This is asking a lot on either side, and people are not always willing to give that much. All too often when a patient says he wants to stay sober, he really means that he wants to stay out of trouble, not get sick, not have people mad at him, but he doesn't mean that he's willing to stop drinking or stop using alcohol as a means of controlling his personal discomfort or the actions of the people around him.

On the other hand, those of us involved with the alcoholic say that we want to help him. Do we mean that *we* want to help *him* or do we really mean that we want him to stop drinking and to conform to *our* standards? It is quite convenient to assume that his drinking is causing him as much difficulty as it is us and that to stop is a very simple matter if he just would. We are not always willing to recognize that we're asking a lot of him and are not always willing to give a lot in return.

There's an old song: "It Takes Two to Tango"—frequently paraphrased: "It Takes Two to Tangle." I would add: "It Takes Two Together." Unless we are all willing to invest a great deal of ourselves, it is not likely that we'll get anywhere in solving the problem of alcoholism.

THE ALCOHOLIC PATIENT

CONTINUED FROM PAGE 15

until he is dried out, generally without medical treatment. If he lands in a hospital, is he received sympathetically? Is he treated with the respect due a human being? For the alcoholic who, in his entire life, has known only rejection, the hospital may be his first opportunity to experience respect. And, respect means acceptance without any strings attached.

I recall one nurse who was trying to get a history from an alcoholic patient on his admission to a hospital. He refused, in no uncertain terms, to cooperate. She assured him that regardless of his behavior he would receive care, then quietly led him to his bed. The next day he looked for the nurse and gave her the information. She had accepted him—with no strings attached.

Respect is indeed a gift of great value to one who has never known its meaning. Some of us react with impatience to the alcoholic; we tell him off, order him to be "sensible," pass him on to someone else. But we need to understand—not act on impulse. The alcoholic may never have been wanted and he may not want himself. Only from the respect he receives from others can he begin to learn a respect for himself.

Referring an alcoholic to a treatment facility requires painstaking care and excellent timing. The patient's readiness for this may never come, and the nurse might be the only professional person who has contact with him. This is a great challenge and takes all the skill she has. Her responsibilities are many and tremendous, and among them is understanding her own attitudes and feelings. She needs also to understand the patient's sensitiveness and emotional loss. The alcoholic is an invalid just as surely as the patient with rheumatoid arthritis, but it is much more difficult to deal with a patient whose handicap is not visible. The care the alcoholic patient especially needs is not given with tangible equipment but with feelings.

All of us have shared his suffering in the past, but we have been luckier and the hurts have not been insurmountable.

A nurse might rationalize that it is easier to ignore this patient than to become involved with her own aversion for him. I don't think she can ignore her responsibility to help. If she gives impersonal physical care, she is not responding to the expectation of her profession. As a nurse, it is her responsibility to accept human nature for what it is.

In trying to understand and accept the alcoholic's behavior, the nurse may give this patient a reason for living on his own terms. From the nurses who have succeeded, others can learn. One nurse was instrumental in getting a patient to go to a tuberculosis clinic by enlisting the help of an unsympathetic relative. The relative utterly rejected the patient except to routinely leave food outside the door of the small room where the alcoholic lived—chronically drunk, desperate, and desirous of dying. The nurse, through adept use of her knowledge, helped the relative respond to the personal element of this human being, which resulted in her being able to take the patient gently by the hand and escort her to the tuberculosis clinic.

Through the efforts of a nurse a mother was able to give birth to her third child without the crisis the birth of her first two children had precipitated. During both of these confinements her husband had gone on a bender and lost his job. Recognizing this as a crisis period, the nurse helped the mother to help her

husband through this pregnancy. Although this is particularly a time when women need support from their husbands, this wife, by leaning temporarily on the nurse, was able to use her own strengths to help her husband. This time he did not go on a bender and he did not lose his job.

The wife of an alcoholic needs to understand that she must live with her husband as he is, or leave him. She can be helped to face her unrealistic expectations and false hopes if someone can alleviate her fears and make her more knowledgeable about alcoholism as an illness. Here is where nurses can be of assistance by explaining that there is nothing that will make a person stop drinking until he wants to stop; that some people stop drinking after a short life of alcoholism, others after many years, and some never, even when treated: that after good intentions, relapses may occur, at which time encouragement is needed.

Well-informed nurses will know about the community resources to which these wives can go for help. One resource is Al-Anon, which offers a program specifically for families and friends of alcoholics.

How can the nurse help the child of an alcoholic parent? By lessening the often inevitable outcome that a child from this kind of home must face—the fight with society—because he, or his parent, has not been accepted. A child needs to identify with good in order to become a secure adult.

One nurse helped a father who, in addition to his job, had the full care of his home and four children. His alcoholic wife spent most of each day in a local barroom. This nurse helped the children gain approval in school by discussing the problem with their teachers, who responded warmly to their needs. She told the father about the lunches available to the children at school and gave him a list of clothing and other things they needed for special school events.

Still another nurse supported the children of an alcoholic father in their love for him, telling them that he was a good man who had an illness which some day might be arrested. Such instances of kindness greatly influence a child's life.

For the adolescent who is trying to find his place in adult life, an alcoholic parent is especially trying. Here again, a sympathetic, understanding nurse can be of help. Alateen, sponsored by Al-Anon, is an organization specifically for the teenage children of alcoholic parents and is one of several community resources they might be referred to for guidance and assistance.

As the nurse works with families in helping them to understand that alcoholism is not a moral weakness but an illness and that drinking is a condition of the illness, she establishes a rapport that insures a good continuing relationship with these families. It goes without saying that the more she knows about the illness and about the community resources prepared to help the alcoholic, the better she is able to apply her professional skills.

It is often not possible for a nurse to estimate what she accomplishes on each encounter with an alcoholic. She cannot always know what she has contributed to his life or see the results. It is difficult to be satisfied with this, but it can be enough if the nurse understands the importance of giving someone a chance to experience worth and dignity, even for the short period of her visit. This might be imparted to a child quietly listening in the room.

The nurse's sense of satisfaction might be mixed, but there is no doubt of the reward when she has involved herself in what is called a life.

Request for Inventory

I have been recently appointed to work in a parish here in North Carolina and so far have had occasion to deal with several alcoholics. One of them gave me a copy of your magazine, *Inventory*. I notice that it will be sent free to those requesting it. Would you please put my name on your mailing list?

Father Robert Bond
Murphy, N. C.

Compliments Article

I want to tell you how very much I enjoyed the March-April, 1963 issue of *Inventory*. I thought the article by Dr. Thomas Jones was especially remarkable in its sincerity and knowledgability. As I may have written on other occasions, I endeavor in a small way to orient some of the medical staff regarding alcoholism, since we have a very large percentage of patients who either are alcoholics or have a very serious drinking problem. Therefore, if it is possible, I should very much appreciate your sending 12 copies of the March-April *Inventory*.

Dorothy S. Fink
Medical Social Worker
Mount Morris Tuberculosis Hospital
Mount Morris, New York

Insight Into Problem

During my recent treatment at Dorothea Dix Hospital at Raleigh following another "slip" in my battle with alcoholism, I became very interested in your program. I was especially benefited by the NCARP literature, as it afforded rare insight into my problem, hence, a chance to recognize and better cope with this illness. Please put me on the mailing list for *Inventory*. Also send me *New Cornerstones* and other literature that you think will help.

Anonymous
Raleigh, N. C.

Psychiatrist Writes

I would like to be placed on the mailing list for *Inventory*. I am a resident of North Carolina and trained at Duke. I am interested in working with alcoholics here in my present assignment.

Capt. K. A. Zener
Psychiatrist, 82nd
Medical Company
82nd Airborne Division
Fort Bragg, N. C.

Interested in Program

While I was a student in the Divinity School of Duke University, I became quite interested in your program of alcoholic rehabilitation. This interest was spurred by your magazine, *Inventory,* which I found to be a constant source of helpful information. Although I have moved from North Carolina, I find alcoholism to be one of the problems confronting my ministry. As I continue to seek new means of helping my parishioners, I would appreciate continued receipt of *Inventory*.

W. Hewlett Stith, Jr.
Associate Minister
Fredericksburg Methodist Church
Fredericksburg, Va.

THE Alcoholic Rehabilitation Clinic of the Los Angeles City Health Department is one of six (now seven: Ed.) such clinics established by the Division of Alcoholic Rehabilitation, State Department of Public Health, on a contractual basis with local governments.

Each clinic is free to formulate treatment philosophy and approaches to the problems of alcoholism. The Los Angeles Clinic employs interdisciplinary knowledge and skills in dealing with this many-faceted illness. The present staff consists of an internist as director; five part-time physicians; a public health nurse; a clinic nurse; two social workers; one senior social worker; a health educator; a part-time clinical psychologist; a part-time psychiatrist; and three clerical workers.

The philosophy of the clinic is based upon the assumption that alcoholism is a chronic debilitating disease of unknown etiology. Subsequently, as with other diseases of unknown etiology, the aim of medical therapy is to maintain the individual as closely as possible to normal physiological functioning. However, very early the staff found that effective treatment of the alcoholic dictated seeing him as he involves himself

AN OUTPATIENT MEDICAL CLINIC APPROACH

Social Work Services

for Alcoholics

And Their Families

Any treatment, to be effective, should include the community, the family and the patient himself.

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in his total life system; psychological, physiological, socioeconomic.

Social work with the alcoholic is designed to support the patient in his attempt to reorganize his life on a nondrinking basis. The extent of this support and the activity involved is dependent on the degree and kind of social disorganization associated with the drinking. Frequently, indirect methods are employed; often they are utilized in conjunction with individual casework. Indirect methods would include correlating services offered to the patient by other agencies, interpreting the illness concept of alcoholism to a patient's employer, securing economic assistance, family counseling, and other social measures.

The core of direct service is the casework interview. Here the focus is on building a helpful relationship between the patient and the worker. Consequently, the caseworker seeks to help the alcoholic reach his attainable goals with due regard for his right to self-determination—his right to reject or accept any plan suggested to him in this mutual relationship. A major hazard is that the worker may fail to realize that he is a part of the patient's environment. As such he is viewed by the alcoholic as part of a total rejecting culture. The caseworker must communicate to the alcoholic that his social work skills are available on a nonjudgmental basis.

In addition to these traditional services, the social worker in the clinic is involved in other activities designed to facilitate the patient's recovery. These activities include family education, community education, and professional education.

Education for the alcoholic's family begins at the time he makes application to the clinic. At this point they are urged to attend a series of lectures designed to show them what they as family members can do to help themselves and the patient live better. Our experiences with families and patients in educational groups led us to become more family centered in our approach to the alcoholic and his problem. This is especially true in relation to the alcoholic's felt need to take a drink. The family response, usually negative from the patient's point of view, reinforces his poor self-image and creates a crisis response—drunkenness. Therefore, we decided to approach this, and related problems, more directly.

The Family As A Unit

Rather than deal with separate mainfestations of aberrant family behavior we began to see whole family groups on a regular basis. We only do this when both spouses give some indication that they are willing or capable of making at least limited positive growth. The major emphasis is placed upon the strengths and weaknesses of the family as a unit. This is done to involve the alcoholic in the family on a contributing basis once again. Often he has become an isolate because of his drinking.

In family interviewing, the presence of the social worker seems to have positive value on the dynamic interactions between family members. The worker's role might be compared with that of the non-directive therapist—guiding the discussion on occasions, clarifying or summarizing issues, drawing out the more silent individual as indicated —generally he is the objective outsider.

No attempt is made to explore unconscious motivation or to develop insight in this area. We encourage the family members to express their attitudes and feelings, and to gain some understanding of other choices they should make. Our experiences with this approach certainly need

further study and exploration; however, the results are most gratifying at this time.

In addition to intensifying existing problems, alcoholism stimulates many others. Consequently, the family with an alcoholic member is a multiproblem family. A cursory survey of 25 families revealed dysfunction in six major areas: (1) money management, (2) sexual adjustment, (3) child rearing, (4) role conflicts, (5) communication, and (6) interpersonal relationships. I should like to illustrate with excerpts from several cases.

Mr. C, a 49-year-old factory worker, was initially seen in individual interviews by the caseworker. After three sessions, he began to complain that his wife saw him as a sinful bum and that the children, aged 21, 19, and 15, no longer respected him because of his spouse's attitude. The worker accepted his reality, supported his worth, but wondered if his drinking didn't contribute to the children's attitudes in addition to what he felt about his mate. Mr. C's concern persisted and the worker began seeing Mrs. C also.

Initially, with Mrs. C, the focus was on her feelings around Mr. C's drinking. She was hostile toward alcoholics in general and felt life had "played a dirty trick" on her by "giving" her an alcoholic husband. After a few months of counseling, concurrent with the educational group, the focus shifted to Mrs. C's inability to talk with her husband and the resultant tensions she felt. In spite of the protective coverings of projection and rationalization, Mrs. C gradually came to accept her own part in stimulating negative behavior in her spouse.

In order to effect these changes, the worker moved away from the detached, objective listener approach to a more direct involvement. He suggested that Mrs. C not insist that her spouse attend church every weekend. The worker knew from Mr. C that he would attend if his spouse did not insist in her "nagging way", as he put it.

Subsequent to several joint sessions with the whole family unit, the C's began to relate feelings about each other which moved from hostile negativism to more positive acceptance. This was at first a threat, but as individual needs were clarified and met, the family made the adjustments. While many problem areas were seen in this situation, the focus was geared to the core problem of poor communication, with the resultant effect of reducing tensions in the peripheral areas.

The second illustration concerns Mr. and Mrs. G. Mr. G, a 46-year-old man, came to the clinic in March of 1959. He had not been drinking for three weeks at the time of intake. His chief complaint was generalized anxiety and tension. He was placed on tranquilizers by the physician and seen on a weekly basis by the social worker. This man, in his psychosocial history, revealed that he had recently been released from prison. Since his release, his wife and two daughters, aged six and eight, were not accepting him.

Mr. G stated he drank because he felt worthless, his family rejected him, he could not secure employment, and drinking gave him the only comfort he knew. However, he realized what was happening to him and sought help to prevent "getting into more trouble."

As a result of his incarceration, Mr. G's family had gone to live in the home of his in-laws with whom he had always been in conflict. Of necessity he was forced to live there upon his return. Now he felt defeated. The significant dynamic in the interview situation was this patient's

use of the ego-defending techniques of rationalization and projection. He blamed his wife for the living arrangements, blamed the culture in general for his other failures.

The worker allowed this man to release his pent-up feelings with minimal interpretation or suggestions. After Mr. G had gained a feeling that the worker accepted him and had some identification with the clinic as a helping agency, the worker decided to see Mrs. G. Mrs. G, a large, pleasant woman in constrast to her husband's diminutive size and drawn appearance, indicated she wanted her marriage to work but felt she did not know her husband any longer. Since his release from prison, she felt her husband had become preocccupied with sex. Mrs. G had become very nervous because they had no privacy in her mother's small home.

In Mrs. G's language the worker explored with her these feelings of anxiety and gave her the feeling that he understood her personal sufferings. The realities of the siutation had to be dealt with. No attempt was made to have Mrs. G make any drastic moves. Rather, she was helped to recognize her ambivalence around the marriage and the family situation.

As both the G's began to gain a better understanding of themselves as individuals, they began solving many of the problems they had posed earlier. For instance, after three months in the clinic, Mr. G got a job. This gave his ego a much-needed boost. After receiving his first paycheck, Mr. G and his wife came to the worker in high spirits. They stated that they had enjoyed a pleasant week-end alone at a resort. They had plans to rent an apartment in the near future, and felt life was treating them very well.

The G's are still seen periodically in the clinic; they have many areas of concern for which they still seek guidance. It would be fatuous to assume their progress is complete, yet they have made meaningful adjustments.

These and other illustrations reinforce in a vivid manner the need to see the alcoholic patient in relation to the major influences in his life. To that end we are committed to the idea of giving priority for social work services to those patients who are still in the family unit. Our rationale for this point of view is derived, in part, from our records, which reflect a high degree of correlation between alcoholism and family discord. Another factor, from a social work point of view, is the general shift in casework to the re-examination of the family centered approach when dealing with psychosocial pathology.

Create Acceptance

Because of the ambivalent matrix from which alcoholism evolves, the social worker, with other staff, feels the need to create within the community the acceptance of alcoholism as an illness. Therefore, we are engaged in specific educational programs to reach various community groups, utilizing media of communication: radio, television, newspaper and speaking engagements.

The problem of alcoholism has come into increasing prominence in the past hundred years. There has developed, intellectually, a recognition of alcoholism as a disease and a growing sense of social responsibility which demands constructive solutions to the problem. Our aim, in this community, is to consolidate this sense of social responsibility because, in a broad sense, any treatment, to be effective, must include the community, the family, and the patient himself.

A feature designed to help you keep posted on developments in the field of alcoholism.

COLUMBIA, S. C.: Columbia will be the scene of the Sixth International Conference of Young People in AA to be held at the Wade Hampton Hotel May 31-June 2, 1963.

RALEIGH, N. C.: Ten scholarships have been awarded by the NCARP to individuals professionally concerned with the illness of alcoholism to the Rutgers Summer School of Alcohol Studies this summer. Recipients include two state probation officers, one parole officer, one AA supervisor from the state prison department, one community alcoholism program director, two ministers, one school social worker, one school guidance counselor and a school administrator.

CINCINNATI, OHIO: The annual meeting and institutes of the National Council on Alcoholism were held April 17-19 at the Hotel Sheraton-Gibson in Cincinnati. The theme of the 1963 meeting was "Alcoholism—Who Is Involved?"

SEATTLE, WASHINGTON: The North American Association of Alcoholism Programs recently announced the appointment of a permanent executive secretary. Richard J. Tatham, director of the Washington State Alcoholism Program since 1958, has been appointed to the new position by Dr. John Philp, president of the NAAAP.

ALBERTA, CANADA: The Alcoholism Foundation of Alberta has undertaken a new education project in conjunction with two provincial tuberculosis sanatoriums. The AFA staff is conducting a program of alcohol education for the medical personnel at the Baker Memorial Sanatorium and the Aberhart Memorial Sanatorium. This program will be extended to patients during 1963.

RALEIGH, N. C.: "Dorothea Dix Hospital's Alcoholism and Drug Addiction Service" is the subject of a new pamphlet now available from the NCARP. Over 1,400 introductory copies were recently mailed to local alcoholism programs, health and welfare departments, family service associations, mental health facilities, the state health and welfare departments, Clerks of Superior Courts and selected physicians and individuals. The pamphlet provides factual information on the alcoholism service of the state hospital in Raleigh to persons who find themselves in the position of having to persuade the alcoholic patient to go to the hospital for treatment. It also attempts to present a realistic appraisal of what the prospective patient can expect from the hospital as well as what the hospital hopes to accomplish with the patient.

RALEIGH, N. C.: A fifth "Summer Studies on Facts About Alcohol" will be conducted under the auspices of the NCARP and Western Carolina College July 1-12, with classes to be held at the Industrial Education Building in Asheville. The course will carry college credit.

NEW BERN, N. C. Representatives of local alcoholism programs throughout the state and other interested persons working with alcoholics gathered at the Hotel Governor Tryon in New Bern May 9 and 10 for the semi-annual meeting of the Alcoholism Programs of North Carolina. Delegates heard Dr. Ernest Campbell and Dr. Richard Simpson, associate professors of sociology at the University of North Carolina, speak on "The Nature of Attitudes" and "Community Power Structure," respectively, at the opening session of the two-day meeting.

Other features of the program included addresses by Dr. Norman Desrosiers, acting medical director of the Alcoholic Rehabilitation Center at Butner, and Mr. E. P. Blair, educator and principal of Vanceboro Farm Life High School; alcohol education workshops and a business session.

Hosts for the APNC meeting were members of the Craven County Council on Alcoholism headed by executive secretary Gray Wheeler.

BOSTON, MASS.: The Fourteenth Conference on Alcoholism sponsored by the Boston Committee on Alcoholism, Inc. was held in John Hancock Hall in Boston on May 8. The theme of this year's meeting was "The Validity of Programs on Alcoholism."

RALEIGH, N. C.: The first issue of "The Story", a quarterly magazine produced by Alcoholics Anonymous members in Central Prison in Raleigh, was published recently. The magazine succeeds "Balance Sheet", a publication of the Central Prison AA group that was suspended in 1961. "The Story" is produced entirely by inmates of the prison with the help of an editorial advisor, one of the prison department's alcoholic rehabilitation supervisors.

MIAMI BEACH, FLORIDA: The 1963 annual meeting of the North American Association of Alcoholism Programs will be held in Miami Beach, October 27-31. The Florida Alcoholic Rehabilitation Program will serve as host agency for the meeting.

RALEIGH, N. C.: The State Board of Health has reported that its 12 community mental health clinics treated and discharged 6,050 patients during the fiscal year which ended last June 30. The report said that 88 percent of the patients treated came from the 20 counties which provide financial support for the clinics. The rest came from 62 other counties. An additional 2,248 patients were seen at the clinics of Duke University and the University of North Carolina, making a total of 8,298.

GREENSBORO, N. C.: Protecting and covering up for the alcoholic employee is the worst thing one can do for him said Dr. Norman Desrosiers, acting medical director of the Alcoholic Rehabilitation Center at Butner, when he spoke to personnel leaders attending Greensboro's Alcohol Education Week recently. Speaking on "The Alcoholic Employee", Dr. Desrosiers said that the sooner the alcoholic seeks help the better. The employee with a drinking problem is a special brand of alcoholic, he said—difficult to discover but easier to pinpoint by clues and signs. Signs pointing to problem drinking include increases in sick leave, gradual deterioration of quality and quantity of work and disagreeableness, he said.

STATE MENTAL HOSPITALS

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mation must go and where the learning must take place before we can hope to see any change in the manner in which interpersonal conflicts are handled; for example, the manner in which children are raised. It is not enough for the mental hygiene-minded professional worker to act as a consultant to people who, in their various capacities, work with other people. There is also a responsibility to use direct approaches to laymen for which there are many direct avenues.

One such avenue is the Church. Through the good efforts of the district chairman of a Church Board of Education, and in cooperation with the local mental health association, a mental health seminar was arranged at one of the churches. The expected turnout of laymen and laywomen of 25 to 30 was more than tripled. Some individuals, hearing of the meeting through the publications of their churches, travelled as far as 50 miles to attend. Many ministers in particular were in attendance. A notable number of adolescents were also present as were a number of older persons. The age range and representation of all walks of life was impressive.

Two hours were given to the workshop during which a film on emotional health was shown followed by a discussion period with questions and answers. The interest evidenced was noted to be genuine and the questions relevant. On the whole, it was felt to be moderately successful.

Another such meeting centered around common problems was held later at another church in the same town which, though it will not be described here, was felt to be quite useful because of better planning and emphasis upon family life.

INPATIENT TREATMENT

CONTINUED FROM PAGE 12

ervision. At no time has the overall problem rate, which is approximately 11 percent, been considered alarming or unusual.

Management failures, which we define as problems severe enough to result in removal to a psychiatric facility, or the necessity for restraints or isolation, have seemed to arise from several causes; the commonest of these is lack of adequate sedation, either prior to entering the assigned room, or thereafter. We consider it extremely important that appropriate drugs in adequate quantity be ordered by the attending physician. The floor nurse feels uneasy when inadequate amounts of the drugs are ordered. This anxiety is frequently perceived by the patient, and restlessness is compounded.

Another common causes of difficulty is admission by subterfuge diagnosis. Such patients bypass the emergency room pre-sedation and can hardly be other than noisy and restless. The floor nurses deeply resent these disguises and might understandably show hostility with the expected result. Also, such patients are unlikely to be accompanied by adequate sedative orders.

Some patients do not respond to the usual remedies. The causes vary from poor nutritional state, extremely prolonged heavy drinking, and unrecognized added addiction to barbiturates or narcotics. Three percent of these patients require transfer to a psychiatric facility. These failures are not consistently predictable.

In conclusion, we believe that with appropriate treatment attitudes, properly trained personnel, a specialized admission procedure, and an adequate treatment protocol, the acutely ill alcoholic may be successfully treated in a general hospital setting.

INDUSTRIAL

MANAGEMENT of the ALCOHOLIC PROBLEM

BY C. NELSON DAVIS, M.D.

and

BRIJ B. SETHI, M.D.

MALVERN INSTITUTE FOR
PSYCHIATRIC AND ALCOHOLIC STUDIES
MALVERN, PENNSYLVANIA

Two staff members of the Malvern Institute discuss steps in formulating a successful alcoholism program in an industrial setting.

This article is reprinted by permission from *The Malvern News*, a publication of the Malvern Institute for Psychiatric and Alcoholic Studies, Malvern, Pa., copyrighted 1963. It was originally presented at a study forum entitled "The Alcoholic in Industry" held at the Malvern Institute in February, 1963 and attended by twenty-five representatives of major business and industrial organizations.

CERTAIN primary steps must be taken to implement any successful program to combat alcoholism in industry. First of all, there must be a recognition, by top management, that alcoholism is a disease. Frequently there will be a resistance to this, perhaps because of the social drinking habits of the executive who refuses to look on a compulsion to drink as the same sort of disease as addiction to narcotics. Or, perhaps he has an alcoholic wife, or other close relative, so that he shuns the thought of drinking being anything but a harmless form of recreation or social relaxation. However, without the recognition by the top echelon that alcoholism is an insidious disease it is impossible to do anything about it on an industrial level.

The second step is the creation of an office or plant policy on alcohol. The employees, from the top down, must be made to realize that the firm recognizes alcoholism as a disease, and is ready to help those who are ready to accept help. Employees must know of the sympathetic awareness on the part of management to the problem, management's knowledge that the problem exists, and that the firm will stand behind those who want help, rather than penalize or discharge them.

The employees must know that when they show interest in overcoming their alcoholic problem, the company will direct them to treatment and assist them while they are getting help. The responsibility, at this second step, should be on the employees themselves. They must know that alcoholism is responsible for a man being fired rather than any desire by management to let him go. Indeed, in most cases management is most reluctant to fire a man until forced into it by the man's behavior as the result of excessive drinking. If the employee has an awareness of

this, through the educational part of the industrial program, he may make a sincere effort to correct the situation before his compulsive drinking leads to his own dismissal.

The next or third step is to educate employees at all levels or classifications to the dangers inherent in drinking. Beginning with those in the top echelon, the educational program should gravitate down through the entire chain of command.

Everyone in the plant should be informed of the dangers from those "Monday morning" accidents, following a weekend of drinking . . . and of the lethal combination of alcohol and gasoline. And every employee should be made aware, by management, of the treatment for alcoholism, and where such treatment is available. He should be made aware of the detrimental effect on his efficiency or productivity when there is an alcoholic in his immediate family.

In this educational program, of course, it is possible to stress the cost of alcoholism to the individual and his family—the losses in wages, inefficiency, in productivity and the loss of happiness in the home.

As the educational program proceeds, the industry should first utilize an open-end, then a closed-end policy. The open-end policy leaves it up to the employee to realize, on his own, that he needs help. Industry with its new sympathetic understanding will direct him to the various treatment centers available.

In the closed-end policy, the alcoholic in the plant or office becomes the strict problem of management. This policy sets a strict set of rules stipulating what the employee can do and what he cannot do, because it now is in the chain-of-command.

In other words, the employee is given the opportunity, first, to do something on his own about the problem. Failing this, it becomes a matter of company action, through the chain-of-command. There are men who must be forced into treatment. Many persons are willing to comply with a company directive, knowing that their job and income depend on it. To successfully carry through a program on alcoholism in industry, the disease must be recognized. Then industry must have an honest desire to come to grips with a problem too long neglected and be motivated by the thought, "It can be done." By the utilization of both an open and closed-end policy, industry has a broad working program without prejudice to the employee.

The company medical department must be oriented so that an employee can talk to the industrial physician about his problem without it necessarily becoming a chain-of-command affair. The physician must thoroughly understand both the open-end and closed-end policies, and be able to judge when the transition from one to the other is necessary. He must be thoroughly familiar with the various treatment centers and the many facets of treatment available, so that he can properly guide the individual alcoholic along the path to an eventual arresting of the disease. An alcoholic is never cured; however, the disease may be arrested by total abstinence.

Another phase in the company's program is the dissemination of information through study-groups . . . again starting with the top echelon. Once the leaders in an industry's management have been thoroughly briefed, the program should be spread over successively lower levels of job classifications.

There must be a foreman-education program. A good foreman should know which of his men are problem drinkers or alcoholics, and direct them to the proper channels for treatment. In the education pro-

gram, no one should be rushed into a hit-or-miss briefing in the problem, for it is complicated and can be misconstrued. In this modern-day culture, instead of recognizing alcoholism as a disease, there is a strong tendency to attach a stigma to it. However, there has been in the past ten years tremendous progress in making people understand that there should be no more stigma to alcoholism than to influenza, tuberculosis, or heart disease.

An initial series of briefings by persons thoroughly informed on the subject can do much to avoid costly mistakes later in the program. If there seems to be sufficient interest in developing these inter-plant programs, Malvern Institute plans to organize formal study groups to pursue the subject further. This group would look into the best methods of developing an effective program within a company to constructively handle the alcoholic problem.

It is not necessary to organize a new staff to effectuate a long-range program for management of the alcoholic problem in an industry. The job can be handled by employees already in the organization. Larger industries may find it advantageous to employ a trained worker whose sole responsibility is directing the alcoholic program.

Any program of this sort should be gradually built over a period of at least five years before it reaches the peak of its vitality and effectiveness. However, this does not mean that an industry must wait five years before results of the program can be achieved. Dividends will be evident shortly after the start of such a long-range program. This has been proven by industries which now have established programs for their alcoholic problems, including DuPont, Eastman-Kodak and Allis-Chalmers.

Questions and Answers from the Meeting on the Alcoholic in Industry:

Question: Would you say that anyone who is a social drinker is potentially an alcoholic? How much drinking do you feel a person must do to be considered an alcoholic?

Answer: Anyone who drinks can become an alcoholic, but volume has nothing to do with it. The reaction of the person to the drink is what is important. A person can be an alcoholic from the first drink or he may drink socially for ten years, then gradually walk into alcoholism.

Question: Dr. Davis, are you saying that drinking does not make a drunk?

Answer: Drinking does not necessarily make a person an alcoholic. Drinking will make a drunk, but you can be a drunk without being an alcoholic.

Question: What would a program, such as the one discussed here, cost industry?

Answer: The cost is minimal. The DuPont program is said to cost about three cents per employee; Allis-Chalmers, a dollar per person. However, remember that Allis-Chalmers' program takes within its scope all the behavioristic problems. DuPont's figure applies only to the alcoholic problem.

Question: Do you believe that industry would be forced to have both the open and closed-end policies?

Answer: Yes. Your educational program will alert persons so that they will seek help of their own accord. Those who get into trouble must be made to understand that either they get well or they get fired.

Question: Do you feel that all the literature, texts and articles in magazines on alcoholism really have an effect upon a person to keep him from drinking or becoming an alcoholic?

Answer: Yes, I think it has a great deal of effect. When I first started in this field, some 30 years ago, the great majority of my patients were between 45 and 55 years of age. Today you find many persons of 21 concerned with the problem. This is true because of education derived from articles on alcoholism. Today people know what alcoholism is,

largely through the information they have obtained through various types of educational media.

Question: As you know, anything that does not make money in industry is thrown out. This makes this type of program very difficult to initiate since top management cannot see the dollar and cents value of such a program.

Answer: This may be true, but there is plenty of evidence in industrial journals as to what alcoholism costs business. It has been said that a conservative estimate of this loss to both business and industry is one billion dollars a year. People cannot visualize this, frequently because of their own involvement in the thing. Industry consistently has remained blind to this problem, although it exists in every business. Industry should play a leading role in combatting a disease as serious and important as this is by establishing a program to help its alcoholic employees. Those firms which already have established such programs have received wide credit for it, as well as having derived great benefit, costwise, in their operation.

Question: What do you do, as a doctor, when you suspect but can't make a diagnosis of alcoholism?

Answer: I will not make a negative diagnosis in borderline cases. I put the full responsibility on the individual so that he makes the diagnosis himself.

Question: You say the closed-end policy actually forces a man to seek treatment. Can you force a person into seeking treatment and be successful?

Answer: Certainly. An alcoholic doesn't have to hit bottom to be treated successfully. You create motivation for them. An ideal person to create the motivation is the employer because he controls the pocketbook.

Question: Do you accept the idea, Dr. Davis, that the job is one of the last places an alcoholic manifests his problem?

Answer: Yes, this is true. A man's drinking is generally first known in the home, then in the community. Usually his fellow employees protect him or cover up for him where he works.

Question: Do you ever make an impression on an individual while he is drinking?

Answer: Never. You just don't get through to a person when he is not thinking correctly.

Question: We can educate people to accept alcoholism as a disease and persuade them to seek treatment, but how do you educate a social drinker to prevent him from becoming an alcoholic?

Answer: There are certain rules a social drinker should follow to avoid becoming an alcoholic. First, never drink alone; second, drink only in a pleasurable environment. The third is to be aware of that time when a cocktail or two doesn't satisfy you. Up until the time you have a craving for more, you are not in trouble. There is prevention in knowing what the disease is and in recognizing the symptoms.

Question: Isn't a fellow employee or a foreman reluctant to tell a friend that he has a drinking problem?

Answer: No, not if they are well-trained by your plant's education program. The fellow employee and foreman must impress on the drinker that if he goes on drinking he not only will lose their friendship but will lose his job as well. The entire program must be well oriented. The degrees of involvement will vary from the top down in the chain of command.

Question: Doesn't the closed-end policy have a greater effect on an employee than the open-end policy?

Answer: No. Once your policy is known and understood by the men, there will be an inner working spirit of cooperation by the employees themselves to help those whose drinking is getting them into trouble—cooperation that might be lacking if it was only handled through the chain of command.

Question: Is there a possibility that the alcoholic is so befuddled that he completely mistrusts both himself and society?

Answer: Yes, and I believe the only thing that will get him over the hump is complete sobriety. Sometimes a man can be "dry" a year or more before he will admit, even to himself, that he is an alcoholic.

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for

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for
(Alcoholics and Their Families)

— Education
— Information
— Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

— Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

— Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Don Dancy, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone ALpine 4-2311.

BURLINGTON—

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Montlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 409½ Broad St., P. O. Box 1466; Phone: 637-5719.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Mrs. Dorothy Ferrell, Psychiatric Social Worker; Phone: TEmple 2-7581, Ext. 421; Hours: Mon.-Fri., 1:00-4:00 p.m.

‡*Aftercare Clinic;* Rex Hospital; Hours: Mon., a.m. and p.m.; Wed., p.m.; Thurs. and Fri., a.m.

†*Mental Health Center of Raleigh and Wake County, Inc.;* 615 Wills Forest Rd.; Phone: TEmple 4-6484 or TEmple 4-6485.

REIDSVILLE—

**Rockingham County Committee on Alcoholism;* Mrs. Anne Wall, Executive Secretary; 225 W. Morehead St., P. O. Box 355; Phone: DIckens 9-4369.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St., P. O. Box 2428; Phone 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 409 E. Marion St.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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